MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09966

93d

CERTIFICATE OF DEATH

Reg. Diat. No. 100

1. PLACE OF DEATH:

County: Charles

City or town: La Plata

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Physicians Memorial Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Charles

City or town: La Plata

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Mary Susie Barbour

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 10, 1860

8. AGE:

Years	Months	Days	If less than one day
87	2	28	..... hrs. ..... min.

9. Birthplace: Va. (town, county, and state)

10. Usual occupation: housework

11. Industry or business

FATHER — 12. Name: Patrick Marks

FATHER — 13. Birthplace: Va

MOTHER — 14. Maiden name: ? Moore

MOTHER — 15. Birthplace: Va

16. Informant: Bruce Barbour

Address: La Plata, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/10/47 (month) (day) (year)

Cemetery or crematory: St. Ignatius

Location: Bel Alton

18. Funeral director: Hunter & Ryon

Address: Waldorf, Md.

19. 11-13 19 47 (Date rec'd by registrar) Julia H. Posey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 8 19 47 at 1:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1, 19 47, to Nov. 8 19 47 and that I last saw h... alive on Nov. 7, 19 47

Immediate cause of death	DURATION
Probably, cerebral thrombosis	Minutes
Due to: Bronchial arteriosclerosis	1-2 yrs +
Due to:	
Other conditions (Give arteriosclerotic heart disease, 2 congestive failure)	1-2 yrs

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op. —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: X Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: John L. McKaraugh, M.D. M. D. or other

Address: La Plata, Md. Date signed 11-5-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

09967

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

131a

Reg. Dist. No. 101

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Charles
City or town: Maryland Point
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Charles
City or town: Maryland Point
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Albert Bastian.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	Married

6.(b) Name of husband or wife: Ivatil Mary Bastian
6.(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): 1869

8. AGE: Years: 78 Months: Days: If less than one day: hrs. min.

9. Birthplace: Charles Co. Md.
(Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business

FATHER
12. Name: Iceland Bastian
13. Birthplace: Charles Co. Md

MOTHER
14. Maiden name: Josephine Dodd
15. Birthplace: Charles Co. Md.

16. Informant: Mrs Mary Bastian
Address: Maryland Point Md.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: Nov. 15, 47
(month) (day) (year)

Cemetery or crematory: Baptist
Location: Nanjemoy Md.

18. Funeral director: Hunter & Ryon
Address: Waldorf Md.

19. Nov. 14 1947
(Date rec'd by registrar)
Mary Swythenbank
Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 13 1947 at 2 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 8 1947 to Nov. 13 1947
and that I last saw h... alive on Nov. 12 1947

	DURATION
Immediate cause of death: Cerebral Apoplexy	
Due to: Cardio-vascular Renal Disease.	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: George C. Bicknell M.D.
M. D. or other
Address: Marlboro Md. Date signed: Nov. 14 47

09968

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1950

CERTIFICATE OF DEATH

Reg. Dist. No. 2100

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County Charles

City or town Rural – Faulkner (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life – 3 mos

Hospital, institution, or street address where death occurred: —

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Charles

City or town Rural Faulkner (If outside city or town limits, write RURAL and give nearest town)

Street No. Lomax Farm – (If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME CAROYLN JOAN BURCH

3.(b) Social Security Number —

4. Sex F

5. Color or race W

6.(a) Single, married, widowed, or divorced Single

6.(b) Name of ~~husband or wife~~ Parent Thomas O Burch father

6.(c) If alive, give age 39 years

7. Birth date of deceased (mo., day, yr.) August 2, 1947

8. AGE: Years 0 Months 3 Days 27 If less than one day ...hrs. ...min.

9. Birthplace Faulkner, Chas Co. Maryland (Town, county, and state)

10. Usual occupation —

11. Industry or business

FATHER 12. Name THOMAS O. BURCH

13. Birthplace Mechanicsville, St Mary's Co.

MOTHER 14. Maiden name Francis Quade

15. Birthplace ORAILLVILE, St Mary Co

16. Informant Father Thomas O. Burch

Address As above

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 30-1947 (month) (day) (year)

Cemetery or crematory St Joseph cemetery

Location Morganza Maryland

18. Funeral director W C Mattingley Sons

Address Leonardtown Maryland

19. 11/29/ 1947 (Date rec'd by registrar) Cummins Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 29 November 1947 at 6:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ......19...... to ......19......

and that I last saw her alive on 10 October 1947

Immediate cause of death	DURATION
Strangulation – aspiration of morning feeding	2 hours
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide No Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H C Woodly MD. M. D. or other

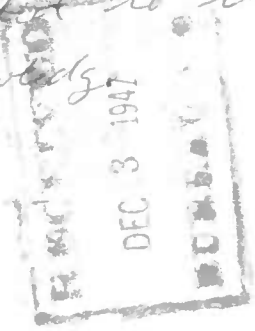
Address Box 214 LaPlata, Md Date signed 29 Nov 47

#4

This child had been in apparent good health until the accident of this morning. The child was fed her usual 3 4 11 feeding while in bed taking 5 oz. When the family awoken at 0600 EST the child was unusually still; closer examinat revealed that the child was dead.

Examination by me at 12 noon 29 November 47 fails to reveal any evidence of external violence. It is my opinion that the child died from the result of aspiration is 3 oz 4 11 feeding.

I in the absence of the State Medical Examiner I have signed this death certificate. The facts are presented to the best of my beliefs and knowledge.



A O Woodley, M.D.
Box 214 LaPlata, Md.
29 November 1947

Birth + Death

05969
09969

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF ~~STILLBIRTH~~

159

Reg. Dist. No. 100

A certificate must be filed within 24 hours for every stillbirth of 20 weeks' gestation or more (see stub)

1. PLACE OF BIRTH:

County Charles

City or town Waldorf

(If outside city or town limits, write RURAL and give nearest town)

Street address, hospital, or institution:

Length of mother's stay in County

(How many years, or months, or days. SPECIFY WHICH)

2. USUAL RESIDENCE OF MOTHER:

State Md.

County Charles

City or town Waldorf

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If RURAL give LOCATION)

3. Name of child Male Campbell

4. Date of birth Nov. 26 1947 Hour 10 00 P.M.

5. Sex Male | 6. Twin or triplet

7. No. of weeks pregnancy 24 weeks.

FATHER OF CHILD

8. Full name William Washington

9. Color Col. 10. Age at time of this birth 25 yrs.

11. Usual occupation Laborer

MOTHER OF CHILD

12. Full maiden name Doris Campbell

13. Color Col. 14. Age at time of this birth 21 yrs.

15. Usual occupation

16. Other children born to mother (not including present child): (a) How many children of this mother are now living? 1

(b) How many other children were born alive but are now dead? (c) How many other children were *born* dead? 1

17. Did child die before labor? No During labor? Yes

18. Pregnancy, complications of No

19. Labor: (a) Complications of Premature Labor

(b) Induced? No

20. (a) Was there an operation for delivery? No (Yes or No)

(b) State all operations, if any None

(c) Did child die before operation? No

During operation? —

21. Cause of stillbirth. Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof.

(a) Fetal causes Prematurity (6 mos.)

(b) Maternal causes Premature Labor

22. I certify to the birth of this child who was born dead* on the date and hour above stated.

Signature John H. Griffin, M.D.

(Specify if M. D., midwife, or other)

Address Hughesville, Md.

23. (a) Burial (b) Date thereof 11-29-47

(Burial, cremation or removal) (month) (day) (year)

(c) Cemetery or crematory Yard of home

24. (a) Funeral director James M. Campbell

(b) Address Waldorf, Md.

25. (a) 11-29-47 (b) J. Alvin H. Posey

(Date rec'd by registrar) (Registrar)

26. (To be filled out if no physician was present at delivery.) The above certificate has been examined by me.

Health Officer, per

V. S. A10

* See Instruction C on stub.

Baby lived 30 minutes

(I)

(T)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

115C

09970

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH:

County: Charles

City or town: La Plata

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? One hour

Hospital, institution, or street address where death occurred:

Physicians Memorial Hospital

How long in hospital or institution? One hour

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Charles

City or town: Spring Hill

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Sofia E. Dyson

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug. 28, 1942

8. AGE:

Years	Months	Days	If less than one day
5	2	10	..... hrs. ..... min.

9. Birthplace: Bel Alton, Charles, Md.

(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER

12. Name: Joseph Robert Dyson

13. Birthplace: Bel Alton, Md.

MOTHER

14. Maiden name: Mary Myles

15. Birthplace: Spring Hill, Md.

16. Informant: Joseph Robert Dyson

Address: Spring Hill, Md.

17. Burial, cremation, or removal. Which?: Burial Date thereof: 11/9/47 (month) (day) (year)

Cemetery or crematory: St. Ignatius

Location: Bel Alton

18. Funeral director: Hewitt & Ryon

Address: Waldorf, Md.

19. 11-9 1947 (Date rec'd by registrar) Julia H. Posey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 7, 1947 at 10 25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

on November 7, 1947 to ..... 19..

and that I last saw her alive on November 7, 1947

Immediate cause of death	DURATION
Acute depression of respiratory center	5'
Due to: Ethyl Chloride poisoning.	5'
Due to: General anesthesia induction	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Chronic tonsillitis

Date of op. 11-7-47

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Deputy Medical Examiner James L. MacNamara, M.D. M. D. or other

Address: La Plata, Md. Date signed 11-7-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

09971

CERTIFICATE OF DEATH

Reg. Dist. No. 105

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

1. PLACE OF DEATH:
County CHARLES
City or town NEWBERG
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 YEARS
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Chas
City or town Waysides Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Ellen Harriet Ford

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	Col	Single

6.(b) Name of husband or wife
B.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1870

8. AGE: Years 77 Months Days If less than one day hrs. min.

9. Birthplace Chas Co
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name Zacariah Fords
13. Birthplace Chas Co

MOTHER 14. Maiden name Elyja Campbell
15. Birthplace Chas Co

16. Informant Virginia Clark
Address Waysides md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-9-47 (month) (day) (year)
Cemetery or crematory Shiloh
Location Waysides md

18. Funeral director Hyatt & Ryon
Address Waldorf md

19. 11-10 19 47 M C Mourd
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-8 19 47 at 9 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
CHRONIC CARDITIS	2 YRS.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Ernest Spencer Jr. M. D. or other
Address Bel Alton Md Date signed 11-9-47

8 472

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a 09972

CERTIFICATE OF DEATH

Reg. Diat. No. 104

1. PLACE OF DEATH:
County Charles
City or town Rock Point
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Charles
City or town Rock Point
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Nellie G. Furbush | **3.(b) Social Security Number**

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife Joseph L. Furbush 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 23, 1884

8. AGE: Years 62 | Months 11 | Days | If less than one day hrs. min.

9. Birthplace King George, Va (Town, county, and state)

10. Usual occupation Housework

11. Industry or business

FATHER 12. Name Martin L. Price
13. Birthplace Va.

MOTHER 14. Maiden name Lucy Ashton
15. Birthplace Va

16. Informant Joseph L. Furbush
Address Rock Point, Md.

17. Burial Date thereof 11/28/47
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Arlington National
Location Arlington, Va.

18. Funeral director Hewitt & Ryon
Address Waldorf, Md.

19. 11/26 1947 William J. Reno
(Date recd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 25 1947 at 4 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 3 1947 to Nov. 25 1947 and that I last saw h[illegible] alive on Nov. 25 1947

Immediate cause of death	DURATION
Epilepsy	22 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE T. L. Haydon M. D. or other
Address Waldorf Date signed Dec. 26-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

117a

09973

CERTIFICATE OF DEATH

Reg. Dist. No. 120

1. PLACE OF DEATH:
County: Charles
City or town: Marshall Hall
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 16 years.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Charles
City or town: Marshall Hall
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Charles Potter Jackson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Sylvia E. Jackson
6.(c) If alive, give age: 49 years

7. Birth date of deceased (mo., day, yr.): June 7, 1890.

8. AGE: Years	Months	Days	If less than one day
57	5	7	...hrs. ...min.

9. Birthplace: Yonkers, N.Y. (Town, county, and state)
10. Usual occupation: Merchant
11. Industry or business: Restaurant

FATHER
12. Name: Joseph Jackson.
13. Birthplace: Yonkers, N.Y.

MOTHER
14. Maiden name: Jenny Vickerman
15. Birthplace: Yonkers N.Y.

16. Informant: Mrs. Chas. P. Jackson
Address: Marshall Hall, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 18 1947 (month) (day) (year)
Cemetery or crematory: St. Charles Catholic
Location: Clymont, Md.

18. Funeral director: Hunt & Ryan
Address: Waldorf. Md.

19. 11-18 19 47 (Date rec'd by registrar) Julia H. Posey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 14 19 47 at 11:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 37 to Nov. 14 19 47 and that I last saw h... alive on November 14 19 47.

Immediate cause of death	DURATION
Peptic ulcer	20 yrs.
Due to	
Due to	
Other conditions: Secondary Anemia	7 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results: ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury: ... Injured at work?

23. SIGNATURE: Frank G. Swan M. D.
Address: Indian Head, Md. M. D. or other
Date signed: 11-14-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

170C

B 09974

Reg. Dist. No. 100

NV

1. PLACE OF DEATH:

County: Charles

City or town: La Plata

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 48 hrs.

Hospital, institution, or street address where death occurred: Physicians Memorial Hospital

How long in hospital or institution? 48 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1776 Willard St. N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME Woodrow Wilson Jackson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) May 16 1919

8. AGE: Years	Months	Days	If less than one day
28			hrs. min.

9. Birthplace: Louisa Co Va. (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER 12. Name: Mercer Jackson

13. Birthplace: Va

MOTHER 14. Maiden name: Hattie Hayden

15. Birthplace: Va

16. Informant: Golden Jackson

Address: 1526 - C St SE. Wash DC

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-15-47 (month) (day) (year)

Cemetery or crematory: Arlington Mem

Location: Arlington Va

18. Funeral director: Hunt & Ryon

Address: Hyattsville Md

19. 11-15-47 (Date rec'd by registrar) Julia H. Casey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 10 1947, at 8:55 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 10, 1947, to 19; and that I last saw him on Nov. 10, 1947

Immediate cause of death	DURATION
Subdural cerebral hemorrhage	48 hrs.
Due to: Automobile accident	48 hrs.
Due to: Struck by auto	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op.: —

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 11-8-47

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) State highway

Means of injury: Struck by auto Injured at work? No

23. SIGNATURE: James S. MacKenzie, M.D., Deputy Medical Examiner

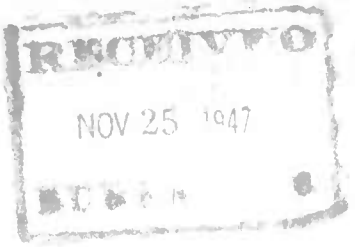
M. D. or other

Address: La Plata, Md Date signed 11-10-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The cooperage is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M


NOV 25 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09975

Reg. Dist. No. 1a5

1. PLACE OF DEATH:

County: Charles County

City or town: La Plata, Maryland.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10/31/47 –

Hospital, Institution, or street address where death occurred: Physicians Memorial Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Pennsylvania County: Mifflin

City or town: Lewistown Pa –

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Howard Knepp –

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	Married

6.(b) Name of husband or wife: Mrs Ruth Knepp.

6.(c) If alive, give age: 32 years

7. Birth date of deceased (mo., day, yr.): May 3, 1913

8. AGE:

Years	Months	Days	If less than one day
34	5	30	..... hrs. ..... min.

9. Birthplace: Lewistown, Mifflin, Pa. (Town, county, and state)

10. Usual occupation: Salesman

11. Industry or business

FATHER — 12. Name: Emery Knepp

13. Birthplace: Pa.

MOTHER — 14. Maiden name: Ida Rickabaugh

15. Birthplace: Pa.

16. Informant: Ruth Knepp

Address: Petersburg, Pa. R.D.1

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/5/47 (month) (day) (year)

Cemetery or crematory: Mt. Rock

Location: Lewistown, Pa.

18. Funeral director: Hunter & Ryon

Address: Waedo, Md

19. 11-5- 1947 (Date rec'd by registrar)

Julia H. Casey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 2 1947 at 12:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from OCTOBER 26 1947 to NOVEMBER 2 1947 and that I last saw h.. alive on NOVEMBER 2 1947

Immediate cause of death	DURATION
ENCEPHALITIS, NON-SPECIFIC	2 DAYS.
Due to: OVERWHELMING VIRUS INFECTION	3 DAYS.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: John H. Griffin M.D.

M.D. or other

Address: Huntingdon, Maryland Date signed: 11-2-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

09976

CERTIFICATE OF DEATH

Reg. Dist. No. 10a

1. PLACE OF DEATH:

County Charles

City or town Bel Alton.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 21 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Charles

City or town Bel Alton.

(If outside city or town limits, write RURAL and give nearest town)

Street No. Old La Plata Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME HENRY HENDERSON LYON

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Married.

6.(b) Name of ~~husband~~ or wife Margaret Olive Lyon

6.(c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) October 14, 1872

8. AGE: Years	Months	Days	If less than one day
75	0	17	...hrs. ...min.

9. Birthplace Chas Co., Maryland.

(Town, county, and state)

10. Usual occupation Merchant.

11. Industry or business —

FATHER 12. Name John Alexander Lyon

13. Birthplace Chas Co.

MOTHER 14. Maiden name C. Isbat Freeman

15. Birthplace Chas Co.

16. Informant Margaret Olive Lyon

Address Bel Alton, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/4/47 (month) (day) (year)

Cemetery or crematory St. Ignatius

Location Bel Alton, Md

18. Funeral director Hunter & Lyon

Address Waldorf, Md.

19. 11-4 1947 (Date rec'd by registrar) Julia H. Posey Registrar

MEDICAL CERTIFICATION

EST

20. DATE OF DEATH 1 November 1947 at 8:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1 November 1947 to 1 November 1947

and that I last saw him alive on 1 November 1947

Immediate cause of death	DURATION
Coronary Thrombosis	12 hrs
Due to Arteriosclerosis	unknown
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation None Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: none

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. B. Woodby M.D. M. D. or other

Address La Plata. Md. Date signed 1 Nov 47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93c

09977

CERTIFICATE OF DEATH

Reg. Dist. No. 100

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. If exact age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Charles

City or town: La Plata

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 77 yrs.

Hospital, institution, or street address where death occurred: —

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Charles

City or town: La Plata

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Matilda Edith Owen

3.(b) Social Security Number:

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Thomas Somerset Owen

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 10, 1869

8. AGE:

Years	Months	Days	If less than one day
77	11	18	hrs. min.

9. Birthplace: La Plata, Charles, Md.
(Town, county, and state)

10. Usual occupation: Housekeeper

11. Industry or business: own home

FATHER

12. Name: Thos. R. Farrall

13. Birthplace: Charles Co., Md.

MOTHER

14. Maiden name: Sarah B. Hancock

15. Birthplace: Charles Co., Md.

16. Informant: Mathilde Owen,

Address: La Plata, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/1/47 (month) (day) (year)

Cemetery or crematory: Sacred Heart

Location: La Plata, Md.

18. Funeral director: Hewitt & Ryan

Address: Waldorf, Md.

19. 12-1 1947 (Date rec'd by registrar) Julia H. Casey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 28 1947 at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 1939 to Nov. 28 1947

and that I last saw h... alive on Nov. 28 1947

Immediate cause of death: Cerebral hemorrhage — DURATION: 6 hrs.

Due to: Generalized arteriosclerosis — 2 yrs.

Due to:

Other conditions: Chr. rheumatoid arthritis — 12 yrs.

Chr. myocardial degeneration — 2 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: James L. MacKaracher M.D.

M. D. or other

Address: La Plata, Md. Date signed 11/28/47

10521

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83d

CERTIFICATE OF DEATH

Reg. Dist. No. 106

1. PLACE OF DEATH:
County: Charles
City or town: Indian Head
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life time
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Charles.
City or town: Indian Head
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: William H. Swann.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	C	Married

6.(b) Name of husband or wife: Emma Swann
6.(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): Oct 10 1871

8. AGE: Years	Months	Days	If less than one day
76	1	-	hrs. min.

8. Birthplace: Indian Head, Md.
(Town, county, and state)
10. Usual occupation: Rigger.
11. Industry or business: Poultry factory.

FATHER
12. Name: William Mitchell
13. Birthplace: Charles Co. Md.

MOTHER
14. Maiden name: Mary Swann
15. Birthplace: Charles Co. Md.

16. Informant: Cecil Swann
Address: Indian Head Md.

17. Burial (Burial, cremation, or removal? Which?) Date thereof: Nov 13 47 (month) (day) (year)
Cemetery or crematory: St. Charles
Location: Glymont
18. Funeral director: Penn & Cofer
Address: Mason Springs. Md.

19. 11/12 47 (Date rec'd by registrar) 18 Adelph Price Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 10 1947, at 12 30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1937, to Nov 1947
and that I last saw h.. alive on Nov. 6 1947.

Immediate cause of death	DURATION
Paralysis	
Due to: Arteriosclerosis	
Hypertension	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: George C. Bicknell M.D.
M. D. or other
Address: Marlboro Md. Date signed: Nov. 12 '47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH NONFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09978

Reg. Dist. No. 284

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Charles

City or town: La Plata

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 24 hrs.

Hospital, Institution, or street address where death occurred: Physicians Memorial Hospital

How long in hospital or institution? 24 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: St. Mary's

City or town: Charlotte Hall

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME: David Joseph Woodland

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife: Agnes Harris

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 27, 1911 ?

8. AGE: Years	Months	Days	If less than one day
35 ?			hrs. min.

9. Birthplace: Charlotte Hall, St. Mary's, Md. (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER — 12. Name: Willie Woodland

13. Birthplace: St Marys Co Md

MOTHER — 14. Maiden name: Eleanor Dent

15. Birthplace: St Marys

16. Informant: Eleanor Dent Willis

Address: Charlotte Hall Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 18 1947 (month) (day) (year)

Cemetery or crematory: Ebenezer

Location: Mrs Market Md

18. Funeral director: Ebenezer M Goode

Address: Hughesville Md

19. Nov. 18 1947 (Date rec'd by registrar) Eleanor S. Canter Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 16, 1947, at 8 10 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 16, 1947 to ~~1947~~ and that I last saw him ~~in life~~ on Nov. 16, 1947

Immediate cause of death	DURATION
2nd & 3rd degree burns upper half of body	24 hrs.
Due to: Accident	
Due to: Kerosene in stove exploded	24 hrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op.

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: 11-15-47

Where did injury occur? Charlotte Hall (City or town) St. Mary's (County) Md. (State)

Injured at home, farm, industry, public place (where?): Home

Means of injury: Kerosene in stove exploded Injured at work? No

23. SIGNATURE: John I. MacKenzie, M.D., Deputy Medical Examiner (M. D. or other)

Address: La Plata Md Date signed: 11-16-47

Jim Willis